

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12967

12984

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Somerset</b>		MARYLAND		2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] a. STATE <b>Maryland</b>		b. COUNTY <b>Somerset</b>					
b. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] <b>Princess Anne</b>		c. LENGTH OF STAY IN lb <b>30 yrs.</b>		c. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] <b>Princess Anne</b>		d. STREET ADDRESS <b>Beechwood Street</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <b>Marie</b>	Middle <b>Marris</b>	Last <b>Baughan</b>	4. DATE OF DEATH <b>Nov.</b>	Month <b>6</b>	Day <b>19</b>	Year <b>59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 24, 1903</b>		9. AGE (In years less birthday) <b>56</b> yrs.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Teaching</b>		11. BIRTHPLACE (State or foreign country) <b>Pamlico Co., N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Leovic Harris</b>		14. MOTHER'S MAIDEN NAME <b>Ada Delamar Harris</b>		Address <b>C.N. Baughan, Beechwood St., Princess Anne, Md.</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchial Pneumonia - Pneumothorax</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <b>157x</b> (b) <b>Anæsthesia - cachexia</b> DUE TO (c) <b>Adenocarcinoma Pancreas.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I attended the deceased from <b>January 3, 1959</b> , to <b>Nov. 6, 1959</b> , that I last saw the deceased alive on <b>Nov. 6, 1959</b> , and that death occurred at <b>1238 M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Med Center Building, 2nd Nov 7, 1959</b>		DATE SIGNED <b>12/28/59</b>							
ACTUAL SIGNATURE <b>William B. Long</b>		M.D.									
PHYSICIAN'S NAME (Type) <b>William B. Long</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-8-59</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Oriental Cemetery</b>		22d. LOCATION (City, town, or county) <b>Oriental, N.C.</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leovic B. Wilson</b>		ADDRESS <b>Princess Anne, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 10 '59</b>		24b. REGISTRAR'S SIGNATURE <b>G. L. K. K.</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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#### **ANSWER**

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July 1966

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#### *Figures*

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12968

12985

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Somerset</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Princess Anne</b>		c. LENGTH OF STAY IN lb <b>Life Time</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x Princess Anne</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>R F D #2</b>		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>Beatrice</b>	Middle <b>Bevans</b>	Last <b>Bevans</b>	4. DATE OF DEATH <b>II 9 1959</b>	Month <b>II</b>	Day <b>9</b>	Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/5/1912</b>		9. AGE (In years (last birthday) <b>47</b> yrs.)	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>	13. IF UNDER 24 HRS. Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			
13. FATHER'S NAME <b>Sidney Bevans</b>		14. MOTHER'S MAIDEN NAME <b>Stella Dashield</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Stella Bevans Princess Anne Md</b>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.2</b>		DUE TO <b>Chronic Myocarditis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>18 months</b>			
Conditions, if any, which gave rise to immediate cause (a), slating the under- lying cause lost. { <b>b</b> )		DUE TO <b>(c)</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>West Post Office, Md</b>		20f. (City or town) <b>West Post Office, Md</b>		(County) <b>West Post Office, Md</b>	(State) <b>Md</b>
21. I certify that I attended the deceased from <b>April 16 1959</b> to <b>Nov 9 1959</b> , that I last saw the deceased alive on <b>Nov 9 1959</b> , and that death occurred at <b>10:30 AM</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>Eldon G. Morrison M.D.</b>						ADDRESS (Street, city or town, state) <b>West Post Office, Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>II/15/59</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>St Mary</b>		22d. LOCATION (City, town, or county) <b>West Post Office, Md</b>		(State) <b>Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William H. James Princess Anne, Md,</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>NOV 16 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur &amp; Thruas</b>			

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
 To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 shall be detached for use as the burial-transit permit. Then please remove corpse-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF STATE - WASHINGTON

CERTIFICATE OF DEATH

WILLIAM

1918-1919

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

12969

**FOR STATE  
HEALTH DERT.**  
**M**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1		Item 3 MilmG260 4-8-60 et										Reg. Dist. No.						
		1. PLACE OF DEATH a. COUNTY  Somerset					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Somerset											
		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne R. F. D.		c. LENGTH OF STAY IN lb Life			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne R. F. D.		d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)																
		3. NAME OF DECEASED (Type or print)		First Margaret Bevins			Middle Cannon Bevins		Lost		4. DATE OF DEATH November 26	Month 1959	Day	Year				
		5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH June 16, 1900		9. AGE (in years last birthday) 59 yr.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days Hours Min.				
		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) Maryland						
		13. FATHER'S NAME John Armwood					14. MOTHER'S MAIDEN NAME Mary L. Hargis					12. CITIZEN OF WHAT COUNTRY? U. S. A.						
		16. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO.					17. INFORMANT Orlandis Bevins, Princess Anne R. F. D. Address						
		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-vascular Accident</b>										INTERVAL BETWEEN ONSET AND DEATH 6 weeks						
		33IX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c)																
		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
MEDICAL CERTIFICATION		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
		20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)				
		21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																
		ACTUAL SIGNATURE <i>R. H. Johnson</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>										DATE SIGNED November 28, 1959				
		EXAMINER'S NAME (Type) R. H. Johnson		22b. DATE THEREOF 11/29/59					22c. NAME OF CEMETERY OR CREMATORIUM St. Mary					22d. LOCATION (City, town, or county) West Post Office Md.				
		23. FUNERAL DIRECTOR'S SIGNATURE <i>Alfred H. James</i>		ADDRESS Princess Anne, Md.					24a. REC'D BY REGISTRAR DEC 2 1959					24b. REGISTRAR'S SIGNATURE <i>Alfred H. James</i>				
VS. AT SME SM 2/57																		

THE STATE OF TEXAS  
EXAMINER'S CERTIFICATE

TEXAS  
EXAMINER'S CERTIFICATE

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12970

12987

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Somerset</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>McCready Memorial Hospital</b>				d. STREET ADDRESS <b>302 N. First St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>LEWIS</b>		First	Middle	Last	4. DATE OF DEATH Month <b>November</b> Day <b>24</b> , Year <b>1959</b>
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>May 25, 1885</b>	9. AGE (In years last birthday) <b>74</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Seafood</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>Hamilton Bradshaw</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Pruitt</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-14-6571</b>		INFORMANT <b>Mrs. Missouri Bradshaw</b>	Address <b>302 N. First St.</b> <b>Crisfield, Maryland</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Topic Myocarditis</b> DUE TO <b>442X</b> INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hemoreni - nephritis with uremia</b> DUE TO <b>17 days</b>					
(c) <b>Arteriosclerotic cardio-vascular Disease</b> DUE TO <b>7 weeks</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Benign Prostatic Hypertrophy &amp; Obstruction - 67 yrs.</b>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8/25</b> , 19 <b>58</b> , to <b>11/24</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>11/23</b> , 19 <b>59</b> , and that death occurred at <b>5:30</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE <b>G. N. Barr, M.D.</b>		C. N. Barr, M.D. Crispell, Md. <b>11/29/59</b>			
PHYSICIAN'S NAME (Type) <b>A. N. Barr, M. D.</b>		Crisfield, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/27/59</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Sunnyridge Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Crisfield, Maryland</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Crisfield, Maryland</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>DEC 4 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12971

12988

## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL** or **ATTENDING PHYSICIAN**: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be re-used by the hospital or attending physician.

**TO FUNERAL DIRECTOR**: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>SOMERSET</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EWELL</b>		c. LENGTH OF STAY IN 1b <b>LIFETIME</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SMITH ISLAND</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X EWELL</b>	
3. NAME OF DECEASED (Type or print) <b>JENETTA</b>		First <b>FRANKLIN</b>	Middle <b>EVANS</b>
4. DATE OF DEATH <b>NOVEMBER 10, 1959</b>		Month <b>NOVEMBER</b>	Day <b>10</b>
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>MARCH 25, 1888</b>		9. AGE (In years lost birthday) <b>71 yrs.</b>	10. IF UNDER 1 YEAR <b>Months Days Hours Min.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>EWELL, SMITH ISLAND, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>LABAN A. GUY</b>		14. MOTHER'S MAIDEN NAME <b>LOUISE CROCKETT</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MRS. RANDOLPH EVANS--EWELL, SMITH ISLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>260X</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO DUE TO (c)			
<b>Coronary disease of heart</b>			
<b>gastrointestinal hemorrhage</b>			
<b>Diabetes mellitus</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>			
5 yrs			
2 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> a. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 1, 1959</b> , to <b>Nov. 10, 1959</b> that I last saw the deceased alive on <b>Nov. 1, 1959</b> , and that death occurred at <b>2 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Ewell, Md.</b>			
DATE SIGNED <b>Barbara M. Hunt, M.D.</b>			
ACTUAL SIGNATURE <b>Barbara M. Hunt, M.D.</b>		PHYSICIAN'S NAME (Type) <b>BARBARA M. HUNT, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>NOV. 13, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>EWELL METHODIST CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>EWELL, SMITH ISLAND, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>BRADSHAW &amp; SONS--CRISFIELD, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 16 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur &amp; Krause</b>	

for days

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12989

## CERTIFICATE OF DEATH

12972

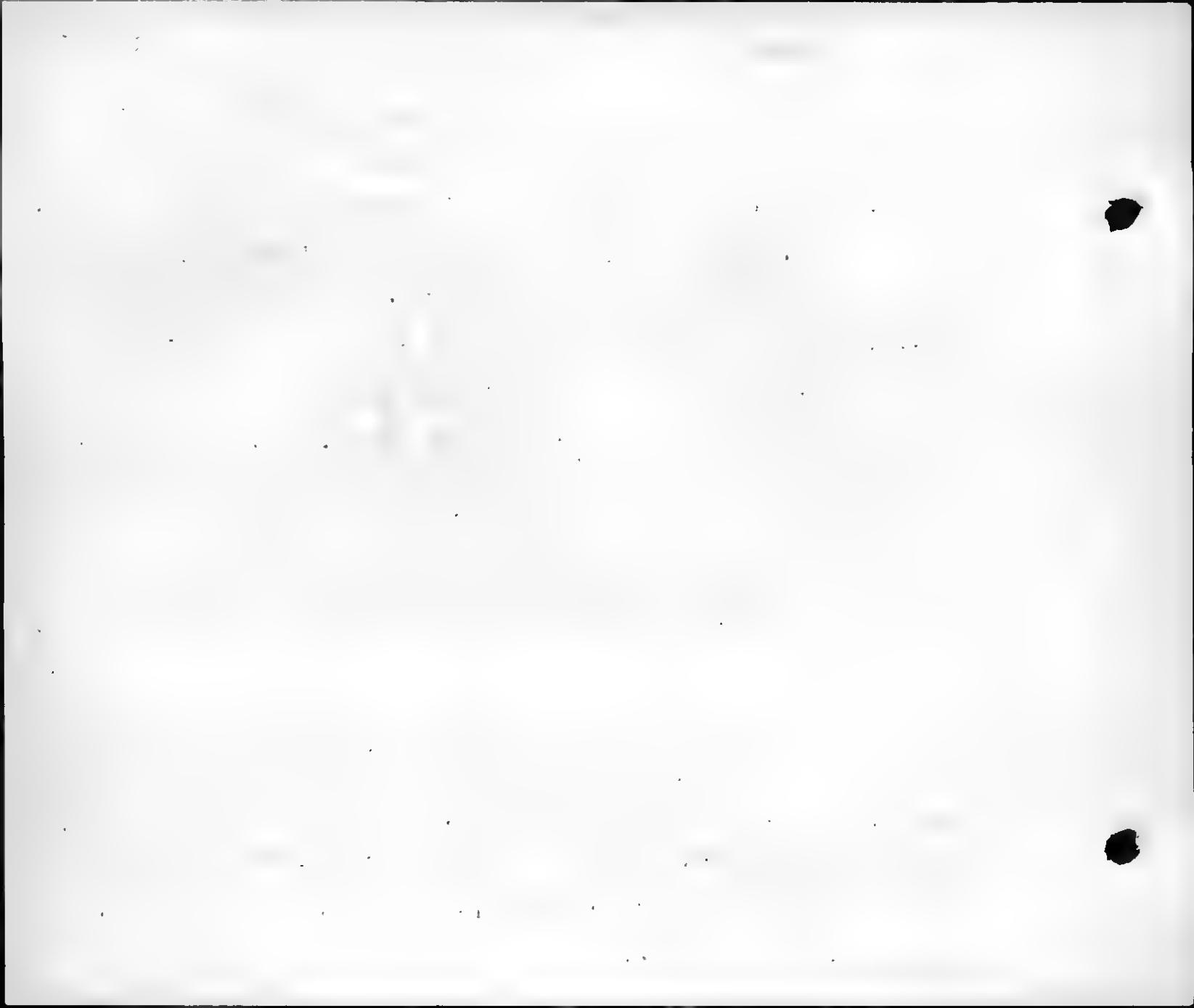
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Somerset</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ewell</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ewell</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Smith Island</b>				d. STREET ADDRESS <b>Smith Island</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>JOHN</b>	Middle <b>ABE</b>	Last <b>EVANS</b>	4. DATE OF DEATH <b>November 13, 1959</b>	Month	Day	Year
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>January 20, 1874</b>	9. AGE (In years last birthday) <b>85</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Seafood</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edward Evans</b>				14. MOTHER'S MAIDEN NAME <b>Trafena Evans</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		INFORMANT <b>Clyde Evans, Ewell, Smith Island, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO <b>cardiac failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO <b>cerebral hemorrhage</b> (c) DUE TO <b>Diabetes Mellitus</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL SEASIDE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 12, 1959</b> , to <b>Nov. 13, 1959</b> , that I last saw the deceased alive on <b>Nov. 12, 1959</b> , and that death occurred at <b>6 AM</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>Ewell, Smith Island, Maryland</b>							
DATE SIGNED <b>14/16/59</b>							
ACTUAL SIGNATURE <b>Barbara Hunt, M.D.</b>							
PHYSICIAN'S NAME (Type) <b>Barbara Hunt, MD,</b> Ewell, Smith Island, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/15/59</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Ewell Methodist Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Ewell, Smith Island, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Crisfield, Md.</b>				ADDRESS		24a. REC'D BY REGISTRAR <b>NOV 19 '59</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hunt</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12990

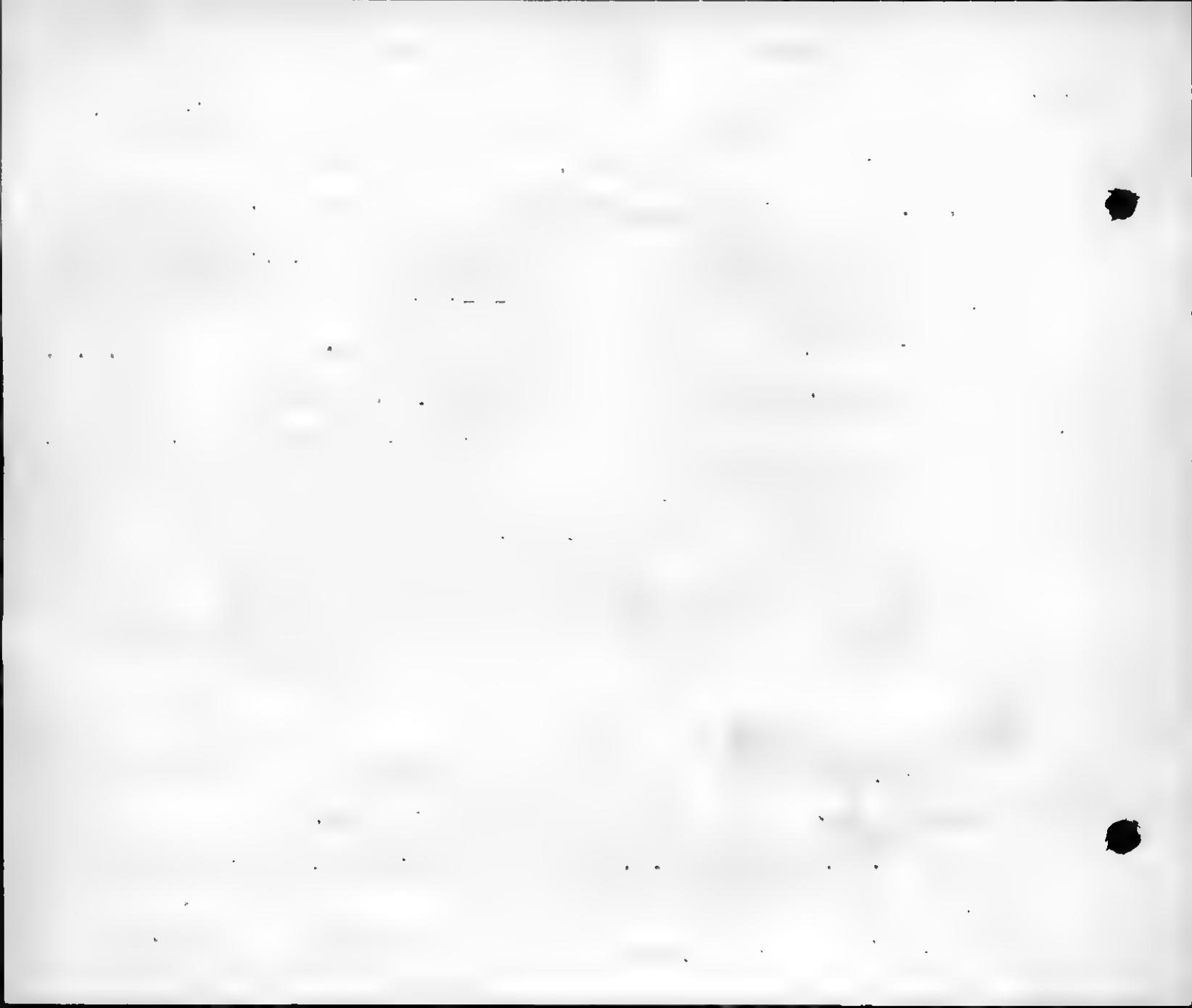
## CERTIFICATE OF DEATH

12973

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it may be retained by the hospital or attending physician.  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 2 hours after death.

1. PLACE OF DEATH a. COUNTY <b>SOMERSET</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b>		c. LENGTH OF STAY IN 1b <b>57 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EDW. W. McCREADY MEMORIAL HOSP.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b>	
3. NAME OF DECEASED (Type or print) <b>VERNON</b>		d. STREET ADDRESS <b>15 ASBURY AVENUE</b>	
4. DATE OF DEATH <b>NOVEMBER 19 1959</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-4-1902</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SEAFOOD DEALER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SEAFOOD</b>	
10c. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>STEWARD EVANS</b>		14. MOTHER'S MAIDEN NAME <b>BELLE MADDRIX</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO INFORMANT <b>LOIS EVANS,</b> Address <b>CRISFIELD, MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY (IMMEDIATE CAUSE (a)) DUE TO <i>coronary thrombosis</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO <i>ulcerative colitis</i>			
(c) DUE TO <i>ischaemic arterio sclerosis heart disease</i>			
INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>NOVEMBER 19 1959</b> , to <b>Nov 19 1959</b> , that I last saw the deceased alive on <b>NOVEMBER 19 1959</b> , and that death occurred at <b>10 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>C. G. Rawley</i>		M.D. <b>MAIN STREET</b>	
PHYSICIAN'S NAME (Type) <b>C. G. RAWLEY, M.D.,</b>		<b>CRISFIELD, MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11/22/59</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Sunnyridge</b>	22d. LOCATION (C'ty, town, or county) <b>Crisfield, Md.</b> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>James Neuman</i>		ADDRESS <b>Crisfield, Md.</b>	
		24a. REC'D BY REGISTRAR <b>NOV 30 1959</b>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Haas</i>



12974

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

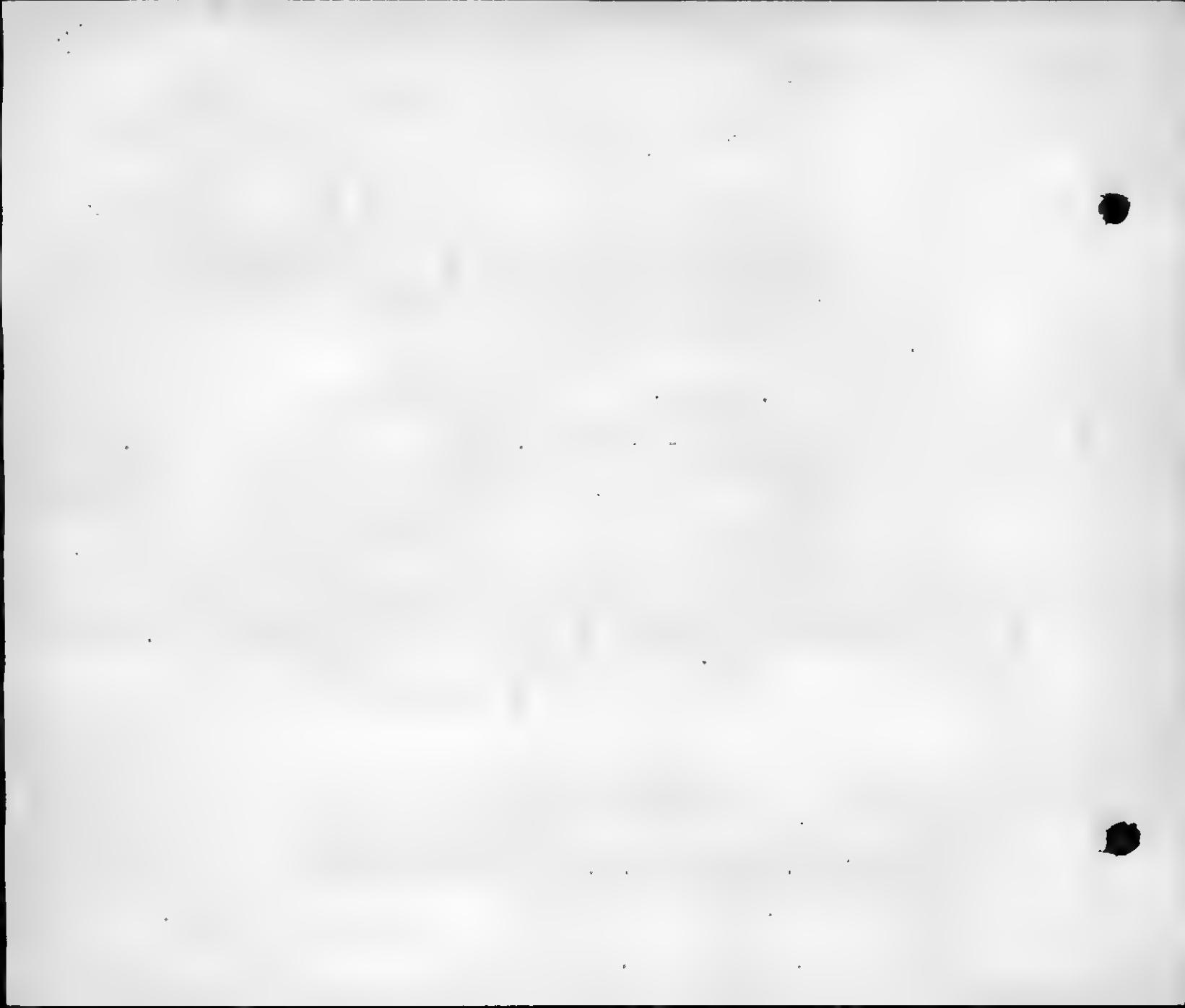
**FOR STATE  
HEALTH DEPT.**

Reg. Dist. No.

To DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in pencil, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-trust permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Somerset</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
1299-1 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Marion</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>RFD #1, Box 17</b>		e. STREET ADDRESS <b>RFD #1, Box 17</b>	
f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>CLARENCE</b>	Middle <b>ELWOOD</b>	Last <b>FONTAINE SR.</b>
4. DATE OF DEATH	Month <b>November</b>	Day <b>1</b>	Year <b>19 59</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 27, 1923</b>
9. AGE (In years last birthday) <b>36</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Farm &amp; Poultry</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Charles H. Fontaine</b>		14. MOTHER'S MAIDEN NAME <b>Lillie Collier</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>219-14-4349</b>	17. INFORMANT Address <b>Mrs. Bronnie Fontaine, RFD Marion, Md.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>42.1</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>	
DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>(b)</b>		William H. Coulbourn, M. D.  DEPUTY MEDICAL EXAMINER  FOR SOMERSBY COUNTY	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).  Complained of feeling badly; lay across bed, found dead few hours later.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  <b>None</b>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  <b>None</b>	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  20f. (City or town)  (County)  (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE  <i>W.H. Coulbourn</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		BATE SIGNED <b>11/3/59</b>
EXAMINER'S NAME (Type)  <b>William H. Coulbourn, M. D.</b>	22b. DATE THEREOF <b>Nov 4, 1959</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Library Cemetery</b>
22d. LOCATION (City, town, or county)  <b>Marion Station, Md.</b>			(State)
23. FUNERAL DIRECTOR'S SIGNATURE  <b>Bradshaw &amp; Sons, Crisfield, Md.</b>	ADDRESS	24a. REC'D BY REGISTRAR DATE <b>NOV 5 '59</b>	24b. REGISTRAR'S SIGNATURE  <i>C. H. Coulbourn</i>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12975

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Somerset</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Somerset</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. LENGTH OF STAY IN Tb <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		d. STREET ADDRESS <b>Asbury Avenue</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>E.W. McCready Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <b>George</b>	Middle <b>E.</b>	Last <b>Lawson</b>	4. DATE OF DEATH	Month <b>Nov</b>	Day <b>22</b>	Year <b>1959</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>11-13-1918</b>	9. AGE (In years (last birthday) <b>41</b> yrs	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Accountant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gas</b>		11. BIRTHPLACE (State or foreign country) <b>Crisfield, Md.</b>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>Lester Lawson</b>				14. MOTHER'S MAIDEN NAME <b>Anne Fleetwood</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT		Address		
				<b>Marie Lawson, Asbury Avenue Crisfield</b>				
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Mycocardial Insufficiency</b> DUE TO <b>420.1</b>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Insufficiency</b> DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL OR SEASIDE CONDITION GIVEN IN PART I(a) <b>Three Previous Myocardial Infarctions</b>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>Janice</b> , 19 <b>55</b> , to <b>Nov 22</b> , 19 <b>59</b> that I last saw the deceased alive on <b>Nov 22</b> , 19 <b>59</b> , and that death occurred at <b>5:30 AM</b> , from the causes and on the date stated above.								
ACTUAL SIGNATURE <b>A. N. Barr, M.D.</b>							ADDRESS (Street, city or town, state) <b>Crisfield, Md.</b>	
PHYSICIAN'S NAME (Type) <b>A. N. Barr, M.D.</b>							DATE SIGNED <b>11/23/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/24/59</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Asbury Cemetery</b>		22d. LOCATION (City, town, or county) <b>Crisfield, Maryland</b> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>James L. Herman</b>		ADDRESS <b>Crisfield, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>Nov 27 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please return to the funeral director. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12981

## CERTIFICATE OF DEATH

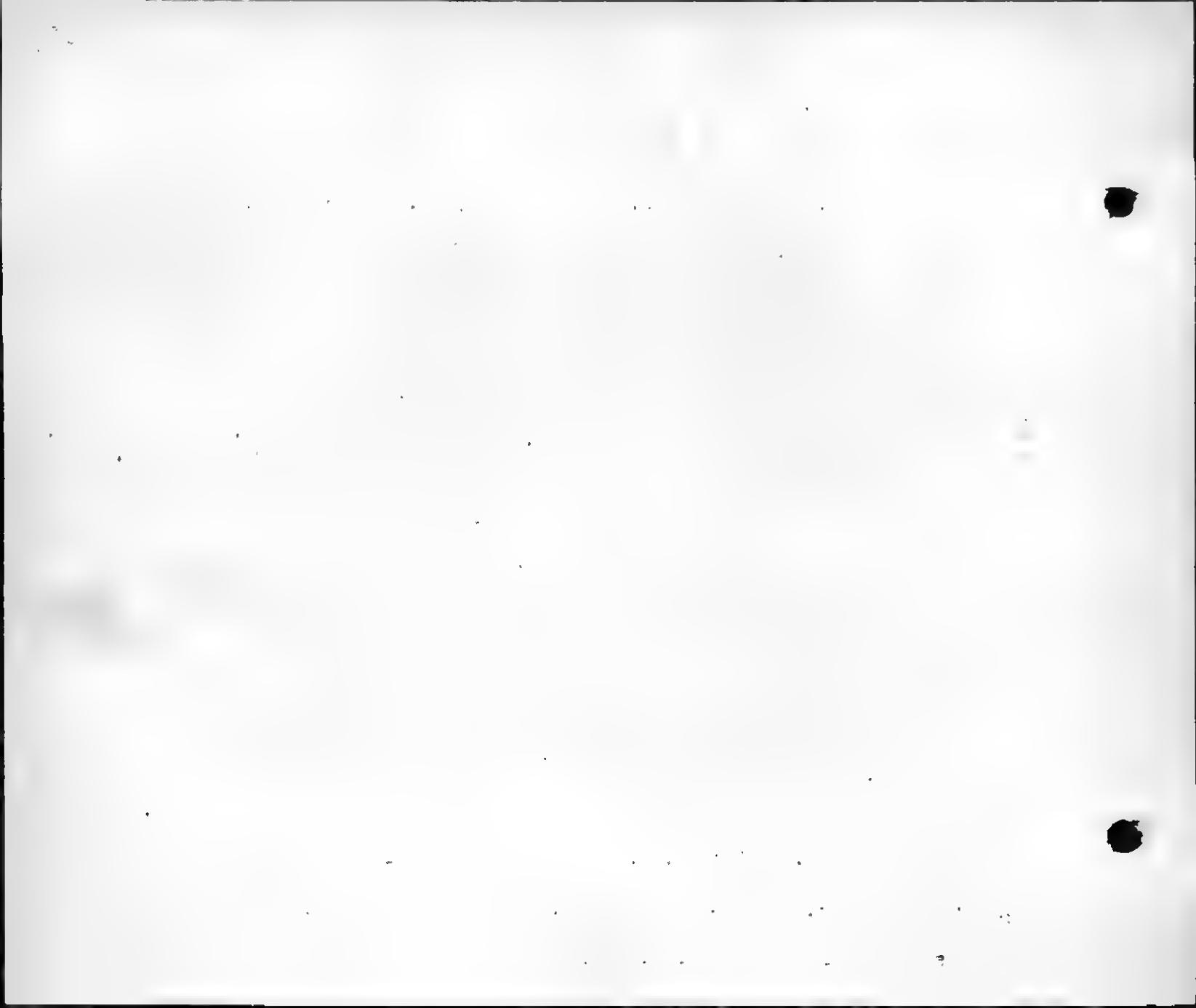
Reg. Dist. No.

12978

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be referred to by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

PLACE OF DEATH o. COUNTY <b>Somerset</b>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY <b>Somerset</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4 E. Chesapeake Ave.</b>				d. STREET ADDRESS <b>4 N. Somerset Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>DORA</b>		First <b>THOMAS</b>	Middle <b>POLEYETTE</b>	Last <b>POLEYETTE</b>	4. DATE OF DEATH <b>November</b>	Month <b>29</b>	Day <b>1959</b>						
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 29, 1874</b>		9. AGE (In years last birthday) <b>85</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Thomas Riggan</b>				14. MOTHER'S MAIDEN NAME <b>Nancy Riggan</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		INFORMANT <b>Mrs. Dorothy McClenahan, 4 E. Chesapeake Ave. Crisfield, Md.</b>		Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO <b>Cerebral Thrombosis or Embolus</b> 2 wks. (c) DUE TO <b>Coronary Thrombosis</b> 2 hrs. 2 hrs.													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Pulmonary embolism</b>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) <b>33 W. Main</b> (State) <b>Crisfield, Maryland</b>	
21. I certify that I attended the deceased from <b>Nov. 1, 1959</b> to <b>Nov. 29, 1959</b> that I last saw the deceased alive on <b>Nov. 29, 1959</b> and that death occurred at <b>10:42 AM</b> , from the causes and on the date stated above.								ADDRESS (Street, city or town, state) <b>33 W. Main</b>		DATE SIGNED <b>Dec. 5, 1959</b>			
ACTUAL SIGNATURE <b>Sarah M. Peyton, M.D.</b>		PHYSICIAN'S NAME (Type) <b>Sarah M. Peyton, M.D.</b>						Crisfield, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 1, 1959</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Sunnyridge Cemetery</b>		22d. LOCATION (City, town, or county) <b>Crisfield, Maryland</b>		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Crisfield, Maryland</b>								24a. DATE <b>Dec. 8, 1959</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>			
ADDRESS								DATE					



12977

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files or to burial premium, or removal.

1. PLACE OF DEATH a. COUNTY <b>Somerset</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Princess Anne</b>		c. LENGTH OF STAY IN lb		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) <b>Maryland</b>		d. COUNTY <b>Somerset</b>	
3. NAME OF DECEASED (Type or print) <b>James Arthur Powell</b>		First	Middle	Last	4 DATE OF DEATH <b>Nov. 3 1959</b>	Month	Day	Year	
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 27, 1881</b>	9. AGE (In years last birthday) <b>78 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>insurance agent</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>James H. Powell</b>		14. MOTHER'S MAIDEN NAME <b>Cornella Miles</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT <b>Mr Howard Green Jr. Princess Anne, Md.</b>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>440.1</b>		Acute Coronary Heart Disease							
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>(b)</b>		Died in his sleep							
DUE TO <b>(c)</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>R. H. Johnson</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED <b>November 5, 1959</b>			
EXAMINER'S NAME (Type) <b>R. H. Johnson</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>11-5-59</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Manokin Pres. Cemetery</b>		22d. LOCATION (City, town, or county) <b>Princess Anne, Md.</b>		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lewis B. Wilson</i>	ADDRESS <b>Princess Anne, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 9 '59</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Klaus</i>				



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

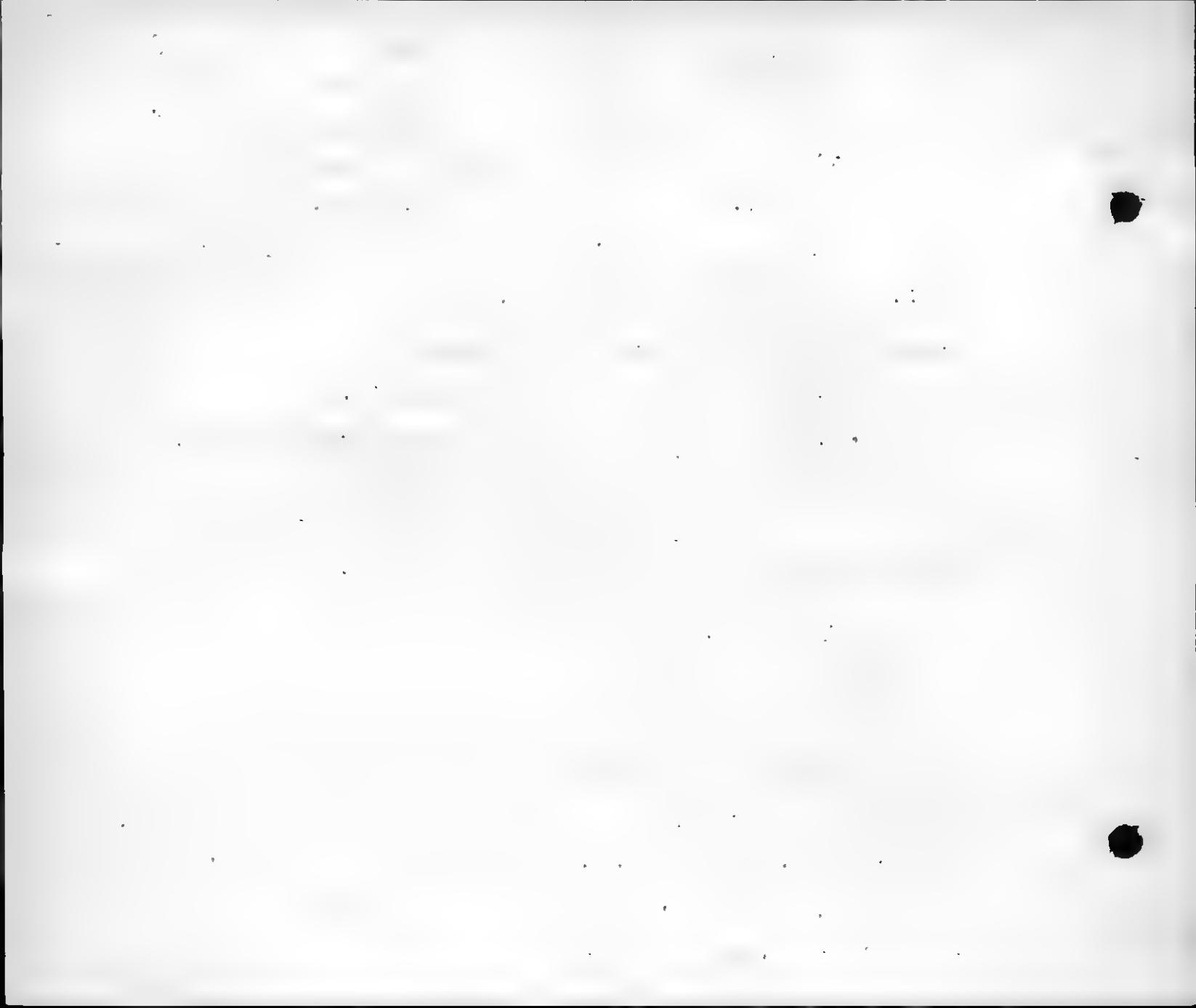
14146

1. PLACE OF DEATH a. COUNTY <b>Somerset</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kingston</b>		c. LENGTH OF STAY IN 1b <b>7 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Kingston</b>		d. STREET ADDRESS <b>Old State Rd.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Old State Rd.</b>						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ELIZABETH</b>		First	Middle	Last	4. DATE OF DEATH <b>RAGUI</b>	Month <b>November</b>	Day <b>28</b>	Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		B. DATE OF BIRTH <b>Jan. 11, 1883</b>	9 AGE (In years last birthday) <b>76</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Theodore Swift</b>				14. MOTHER'S MAIDEN NAME <b>Matilda Matthews</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>Mrs. Dora Henss, Kingston, Maryland</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO		<i>Myocardial Infarction - Acute bil. of Heart</i>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b)		DUE TO		<i>C. Myocarditis C. Dut Nephritis</i>		<b>years</b>			
(c)									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				<i>General Atherosclerosis - Senility</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <b>Nov. 16, 1959</b> , to <b>Nov. 28, 1959</b> , that I last saw the deceased alive on <b>Nov. 28, 1959</b> , and that death occurred at <b>1:00 AM</b> , from the causes and on the date stated above						ADDRESS (Street, city or town, state) <b>Marion Sta. Maryland</b>			
ACTUAL SIGNATURE <i>George C. Coulbourn</i>		M.D.				DATE SIGNED <b>11-30-59</b>			
PHYSICIAN'S NAME (Type) <b>George C. Coulbourn, M. D.</b>				Marion Station, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 29, 1959</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Sunnyridge Cemetery</b>		22d. LOCATION (City, town, or county) <b>Crisfield, Maryland</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Crisfield, Maryland</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>DEC 8 '59</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be re-entered by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it may be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 File#254 1-14-60 et

12995

## CERTIFICATE OF DEATH

Reg. Dist. No.

12978

1. PLACE OF DEATH a. COUNTY Somerset		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland		b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmount		c. LENGTH OF STAY IN lb life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmount		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First Robert	Middle Bain	Last Revelle	4. DATE OF DEATH Month November 9, Day 1959
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5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 29, 1883	9. AGE (In years last birthday) 76 yrs	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postmaster	10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (State or foreign country) Fairmount, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.
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13. FATHER'S NAME John H. Revelle	14. MOTHER'S MAIDEN NAME Sarah Ford
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO	INFORMANT Mrs. Jeanie Revelle: Fairmount, Md.	Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		4 days
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last		DUE TO <i>Myocardial Infarction</i>
(b)		<i>Coronary Insufficiency</i>
DUE TO (c), <i>Generalized Arteriosclerosis &amp; Hypertension</i>		3 1/2 m - knows
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>

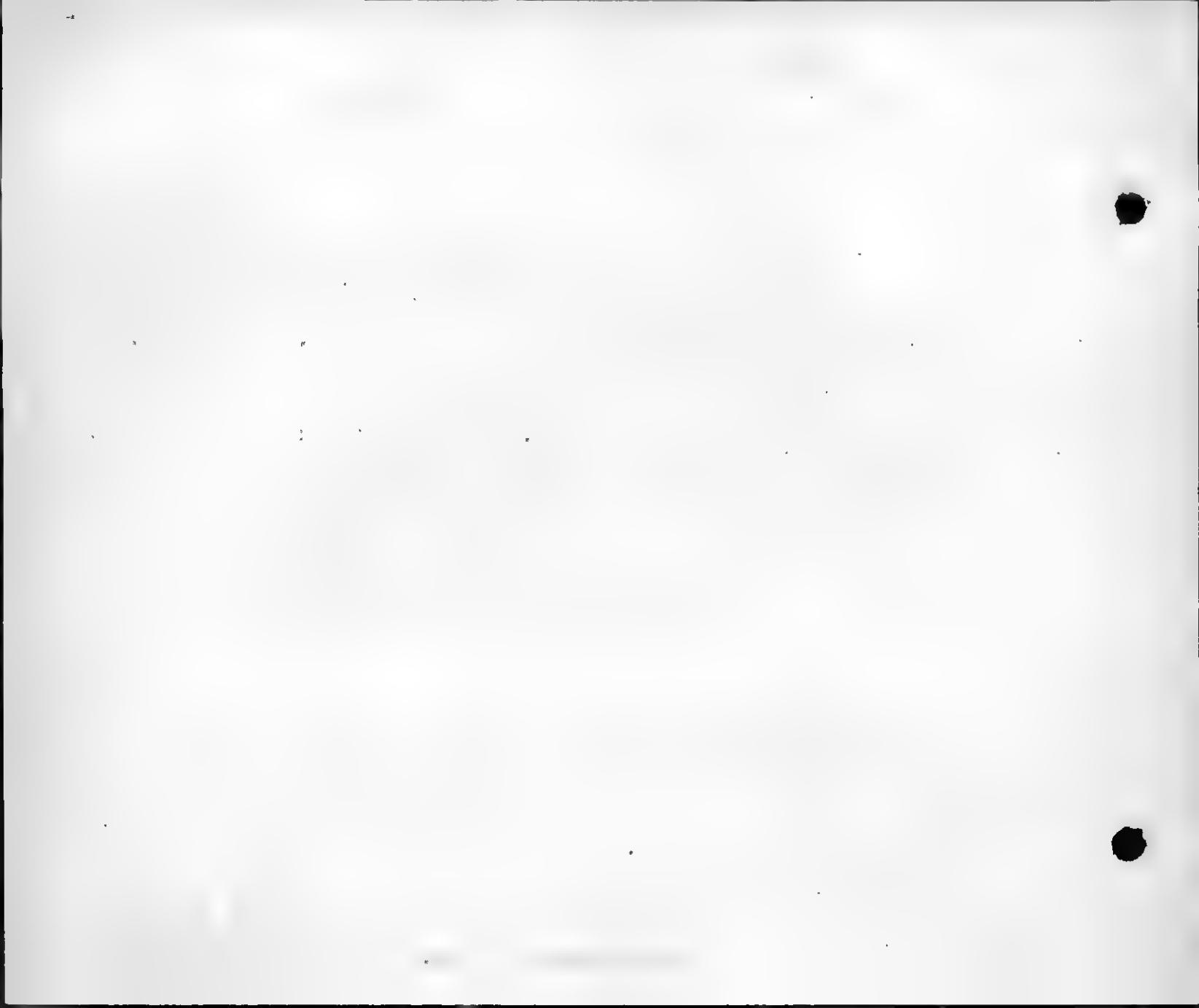
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month. Day. Year Hour o m p m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7-9, 1955, to 11-9, 1955, that I last saw the deceased alive on 10-26, 1959, and that death occurred at 10 A.M. from the causes and on the date stated above.
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ACTUAL SIGNATURE <i>A. N. Barr, M.D.</i>	M.D.	ADDRESS (Street, city, or town, state) <i>Crisfield, Md.</i>	DATE SIGNED <i>11/14/59</i>
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PHYSICIAN'S NAME (Type) <i>A. N. Barr, M.D.</i>	22b. DATE THEREOF 11/11/59	22c. NAME OF CEMETERY OR CREMATORIUM Fairmount	22d. LOCATION (City, town, or county) Fairmount, Maryland (State)
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23. FUNERAL DIRECTOR'S SIGNATURE <i>Jesse H. Henson</i>	ADDRESS Princess Ann, Md.	24a. REC'D BY REGISTRAR NOV 18 '59	24b. REGISTRAR'S SIGNATURE <i>Charles S. Kraus</i>
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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12979

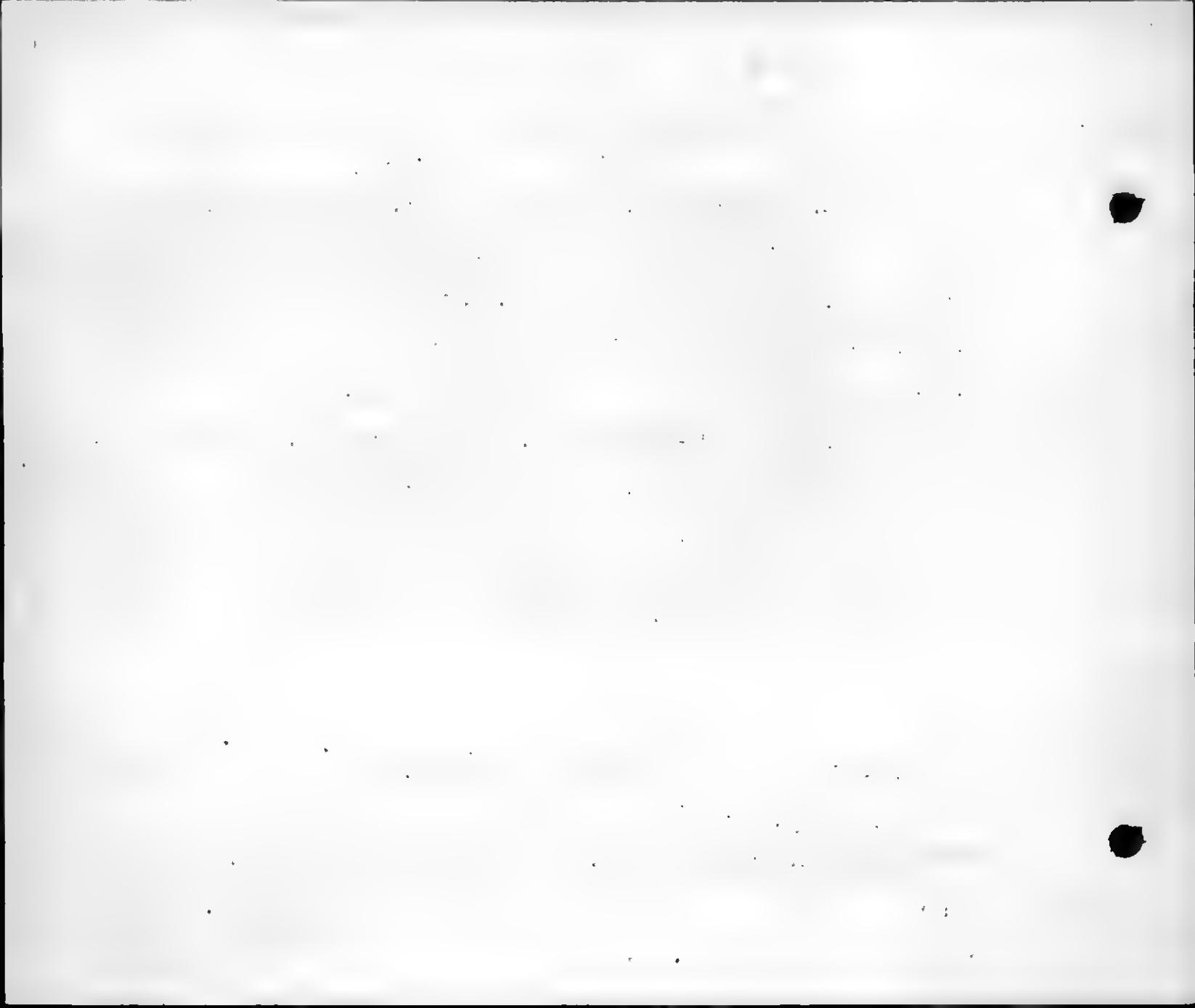
12982

## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL** ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it may be retained by the funeral director.  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE	
Somerset MARYLAND		Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN 1b 31 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 18 E. Chesapeake Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First ROBERT	Middle CLEVELAND	Last TYLER
4. DATE OF DEATH	Month November	Day 27	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 4, 1885
9. AGE (In years last birthday) 74 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dealer & Packer	11. KIND OF BUSINESS OR INDUSTRY Seafood	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Andrew Tyler	14. MOTHER'S MAIDEN NAME Charlotte Messick		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO None	INFORMANT Mrs. Carrie Tyler, 18 E. Chesapeake, Crisfield,	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Wesome Acute Dis of Heart</i> INTERVAL BETWEEN ONSET AND DEATH <i>2 week</i> 1422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <i>Chronic myocardial Change due to nephritis</i> (c) <i>5 years</i>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>General Arteria Sclerosis</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>	
20c. TIME OF INJURY Hour o. m. — p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Nov. 15</i> , 1959, to <i>Nov. 27</i> , 1959, that I last saw the deceased alive on <i>Nov. 26</i> , 1959, and that death occurred at <i>7 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Marion Station, Md.</i> DATE SIGNED <i>George C. Coulbourn</i>			
ACTUAL SIGNATURE <i>George C. Coulbourn</i>		M.D.	
PHYSICIAN'S NAME (Type) George C. Coulbourn, M. D.		Marion Station, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/29/59	22c. NAME OF CEMETERY OR CREMATORIUM Sunnyridge Cemetery	22d. LOCATION (City, town, or county) Crisfield, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Md.		24a. REC'D BY REGISTRAR DATE DEC 8 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>



18  
FOR STATE  
HEALTH DEPT.  
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

12980

Reg. Dist. No.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death, if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained by your files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Somerset</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Michigan</b>		b. COUNTY <b>Schoolcroft</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Deal Island</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Manistique</b>		d. STREET ADDRESS <b>315 Range Street</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Hunting Lodge</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Russell</b>		First	Middle	Lost	4. DATE OF DEATH <b>November 30, 1959</b>	Month	Day	Year
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 12, 1891</b>	9. AGE (in years last birthday) <b>68 yrs.</b>	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Commercial Forester</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Minnesota</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Dwight H. Watson</b>				14. MOTHER'S MAIDEN NAME <b>Clara Merritt</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service) <b>yes</b>		16. SOCIAL SECURITY NO. <b>W.W. I unk.</b>		17. INFORMANT <b>Dennis Youngblood - Ardmore, Pennsylvania</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Acute Coronary Heart Disease				INTERVAL BETWEEN ONSET AND DEATH sudden		
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b)		DUE TO						
(c)		DUE TO						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month Day Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)
19								
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>R. H. Johnson</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>12/1/59</b>		
EXAMINER'S NAME (Type) <b>R. H. Johnson, M.D.</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-5-59</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Fairview Cemetery</b>		22d. LOCATION (City, town, or county) <b>Manistique, Michigan</b>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Webster Princess June</i>		ADDRESS <i>md</i>		24a. REC'D BY REGISTRAR DATE DEC 2 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>		



1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12981

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be exercised within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial; cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		Reg. Dist. No.	
Somerset MARYLAND		a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
Crisfield	lifetime	39 Crisfield			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?		
705 Broadway	705 Broadway		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First RONNIE	Middle A.	Last WILLIAMS	4. DATE OF DEATH	Month November Day 4 Year 19 59
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years for birthday)	IF UNDER 1 YEAR Months 1 Days 3 Hours Min.
Male	Negro	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Oct 1, 1959	No yrs.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
None (Infant)		None (Infant)		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Edward Thomas		Irma Williams		USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT	
(If yes, give war or dates of service) None		None		Irma Williams, 705 Broadway, Crisfield, Md.	
Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Prematurity; not well developed.		Since birth	
776 X					
DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Very small since birth.		II II	
DUE TO					
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Died during night in sleep. No doctor in attendance.				William H. Coulbourn, M. D.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part II of Part I if item None)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				DEPUTY MEDICAL EXAMINER 20. (City or town) (County) (State) FOR SOMERSET COUNTY, MD.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				DATE SIGNED 11/4/59	
ACTUAL SIGNATURE <i>William H. Coulbourn</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) William H. Coulbourn, M. D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 4, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Lawsonia AME Cemetery	
				22d. LOCATION (City, town, or county) Crisfield, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE NOV 6 59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Trahan	

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